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August 31, 2010

TO: Each Supervisor

FROM: John F. Schunhoff, Ph.D.
Interim Director

SUBJECT: **MEDI-CAL TREATMENT AUTHORIZATION REQUEST (TAR) APPROVAL AND DENIAL ACTIVITY**

On July 20, 2010, your Board requested the Department to provide the most recent quarterly report on denied days which should include the reasons for denial. Attached is the Medi-Cal Treatment Authorization Request (TAR) Approval and Denial Activity, Fiscal Year (FY) 2009-10 (July – March Year-To-Date) Full Scope and Limited Scope Medi-Cal Beneficiary Service Days for the Department's four hospitals.

The attached indicates 147,225 days (includes all dates of service for multiple FY's) were presented to the State Medi-Cal Field Office (MFO) for review and 125,708 days (85.4%) were approved, and 21,517 days (14.6%) were denied. The three largest categories of denied days are (1) Level of Care Not Justified (37.0%), (2) Delay in Requesting or Providing Services (30.2%), and (3) Continued Stay for Which There is No Medi-Cal Authorization (25.6%).

"Level of Care Not Justified" refers to TAR denials where the State MFO believes there was no justification for acute inpatient admission and the care could have been provided on an outpatient basis. "Delay in Requesting or Providing Services" denials occur when scheduled services, e.g., surgery, must be delayed because of higher priority emergency admissions. "Continued Stay for Which There is No Medi-Cal Authorization" refers to denied days where the patient is no longer receiving acute care and can be discharged, but there is no appropriate level placement facility available.

In addition, this report tracks denials in two other categories, "Admission" denials which occur when the medical record does not explain acute care provided to the MFO's satisfaction. An "Administrative" denial occurs when a patient is admitted for observation purposes only.

In comparing FY 2008-09 to 2009-10 denied day activity (percentage to denial), we have seen slight improvement in Admission Denials, Delay In Requesting or Providing Services, Continued Stay For Which There Is No Medi-Cal Authorization For Care, and Administrative Denials. However, Level of Care Not Justified increased slightly.

TARs for multiple fiscal years were processed during this period, which is the normal practice. This is because TARs are reviewed retroactively, following patient discharge and, per State requirement, always following verification of Medi-Cal eligibility

Medi-Cal TAR processing has been exceptionally difficult in recent years as a result of State employee furloughs, hiring freezes, and lack of overtime, etc., resulting in a TAR backlog of approximately 10,000 admissions. The State MFO in Los Angeles has made efforts to reduce this backlog by having 'TAR parties' (additional review nurses are assigned for a short period of time to concentrate on processing backlogged TARs); however, because of the TAR review workload and State employee furloughs, the backlog continues to grow.

Various solutions to resolve the backlog have been considered, including hiring additional MFO staff. However, there is concern that even if the State hired additional staff to meet TAR processing needs throughout the State (which is unlikely given the State's fiscal situation), the TAR denial rate could increase as new inexperienced personnel grapple with the subjective and inexact guidelines of TAR review.

The Department has proposed substituting the current manual TAR process with an electronic, evidence-based admission and continued stay Utilization Management Decision Support system (InterQual) as part of the new 1115 Waiver. InterQual is the system used by the Medicare program to determine the appropriateness of admission and continued stay, and the Department is moving forward with its plans to implement InterQual at its four hospitals.

Each of our hospitals have: Utilization Review plans in place to address denied days, hospital Utilization Review (UR) Committees overseeing the work of the hospital UR departments, and the Department just recently reconstituted the DHS UR Committee (URC) to address denied days. At the August 19, 2010 DHS URC meeting, the group decided to explore the use of Clinical Documentation Specialists, a program UC Irvine (UCI) put in place to improve documentation and coding, which in turn helped UCI address payor denials.

Please let me know if you have any questions or require additional information.

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Attachment

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

LOS ANGELES COUNTY - DEPARTMENT OF HEALTH SERVICES
MEDI-CAL TREATMENT AUTHORIZATION REQUEST (TAR) APPROVAL AND DENIAL ACTIVITY (a) (b)
FISCAL YEAR 2009-2010 JULY - MARCH YTD

FULL SCOPE AND LIMITED SCOPE MEDI-CAL BENEFICIARY SERVICE DAYS (c) (d)

1	2	3	4	5	6	7	8	9	10
			Number of Denied Days						
Hospital	Total Number of Medi-Cal Days	Total Number of Approved Days (e) (f)	Category 100 Admission Denial	Category 200 Level of Care Not Justified	Category 400 Delay In Requesting or Providing Services	Category 500 (g) Continued Stay For Which There Is No Medi-Cal Authorization For Care Including Homeless	Category 600 Administrative	Total Number of Denied Days	Total Denied Days % (h)
LAC+USC MC	66,253	55,336	912	2,297	3,365	4,309	34	10,917	16.48%
H/UCLA MC	40,957	33,759	316	3,385	2,690	691	116	7,198	17.57%
RLANRC	19,605	17,457	57	1,724	250	117	0	2,148	10.96%
OV-UCLA MC	20,410	19,156	122	553	182	397	0	1,254	6.14%
Grand Total	**147,225**	**125,708**	**1,407**	**7,959**	**6,487**	**5,514**	**150**	**21,517**	**14.6%**
Percentage To Total	**100%**	**85.4%**	**1.0%**	**5.4%**	**4.4%**	**3.7%**	**0.7%**	**14.6%**	
Percentage To Denial			**6.5%**	**37.0%**	**30.2%**	**25.6%**	**0.7%**		

Medi-Cal Denial Reason Category Legend

Category 100 - No medical justification for admission [the medical record did not explain to Medi-Cal's satisfaction 1) why the patient required acute inpatient hospitalization instead of outpatient care, and 2) that the acute care provided was medically necessary]

Category 200 - Acute level of care not justified by medical record documentation [the medical record, e.g., progress notes and projected workup and treatment plan, did not explain to Medi-Cal's satisfaction why continued acute hospitalization was medically necessary]

Category 400 - Days of care denied because of delay in provision of scheduled medical services [e.g., surgery was delayed for reasons other than the patient's medical condition, such as an emergency admission requiring a scheduled surgical suite causing a planned surgery to be cancelled and the patient must wait to be rescheduled]

Category 500 - Continued stay where the patient no longer requires acute medical care and can be discharged, but appropriate level placement facility is not available and/or there is no home placement possible [Medi-Cal may authorize administrative day reimbursement contingent upon hospital meeting Medi-Cal Field Office requirements]

Category 600 - Administrative denial [medical record not available, or patient admitted solely for observation purposes to rule out a particular medical concern that could require inpatient admission]

Footnotes

(a) The number of approved and denied days reflect TAR dispositions processed during Fiscal Year 2009-2010 July-March YTD, but actually comprise of a preponderance of prior calendar years dates of service because the Medi-Cal Field Office 1) only accepts TARs for review after Medi-Cal eligibility has been established and 2) is not staffed to perform Concurrent Review, i.e., TARs are not reviewed until after the patient has been discharged.

(b) Does not include psychiatric days or administrative days data. Administrative days at significantly reduced reimbursement may be authorized by Medi-Cal when the patient is no longer receiving acute care and requires placement, but there is no appropriate level placement facility available.

(c) Full Scope beneficiary service days as defined in California Code of Regulations Title 22, Section 51303, are health care services which are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

(d) Limited Scope Beneficiaries are only eligible to Medi-Cal coverage for pregnancy or emergency services. Emergency services as defined in California Code of Regulations Title 22, Section 51056, means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

(e) Includes both Full Scope and Limited Scope approved days.

(f) May also include approved days resulting from successful appeal of TAR denials and TAR litigation settlements.

(g) Placement problem for which there is no Medi-Cal reimbursement for acute care.

(h) Total approved days plus total denied days the sum of which is then divided into total denied days.

Source: Hospital Utilization Review Departments